UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

JEFF COLEMAN, Plaintiff, v. MICHAEL J. ASTRUE, Commissioner of Social Security, Defendant.	Case No. 07-CV-1722-JM (JMA) **ORDER (1) GRANTING PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT [DOC. NO. 11] (2) DENYING DEFENDANT'S CROSS-MOTION FOR SUMMARY JUDGMENT [DOC. NO. 16], AND (3) REMANDING CASE FOR FURTHER PROCEEDINGS**

Plaintiff Jeff Coleman ("Plaintiff") seeks judicial review of Defendant Social Security Commissioner Michael J. Astrue's ("Defendant") determination that he is not entitled to disability insurance and supplemental security income benefits. The parties have filed cross-motions for summary judgment. Pursuant to 28 U.S.C. § 636(b)(1)(B) and Civil Local Rule 72.1(c)(1)(c), the motions were originally referred to Magistrate Judge Jan M. Adler for a Report and Recommendation. The Court hereby withdraws the referral and finds these matters suitable for determination.

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As set forth below, the Court **GRANTS** Plaintiff's motion for summary judgment, **DENIES** Defendant's cross-motion for summary judgment, and remands the case for further proceedings.

I. PROCEDURAL HISTORY

Plaintiff filed an application for disability insurance benefits on or around June 3, 2005 alleging a disability onset date of January 1, 2002. (Admin. R. at 15, 72-74.) Plaintiff also protectively filed an application for supplemental security income on April 29, 2005. (Id. at 15, 487-89.) Plaintiff's disability claim was denied initially on July 25, 2005, and again upon reconsideration. (Id. at 61-71.) Plaintiff requested a hearing before an Administrative Law Judge ("ALJ"). Administrative hearings were conducted on November 20, 2006 and January 18, 2007 by ALJ James S. Carletti, who determined that Plaintiff was not disabled. (Id. at 15-23.) Plaintiff requested a review of the ALJ's decision; the Appeals Council for the Social Security Administration ("SSA") denied Plaintiff's request for review on May 24, 2007. (Id. at 8-10.) Plaintiff then commenced this action pursuant to 42 U.S.C. § 405(g).

II. FACTUAL BACKGROUND

Plaintiff was born on June 15, 1956. (Id. at 72.) He has previously worked as a grocery store bagger, molder at a manufacturing plant, customer service representative, stock person, and production mechanic. (Id. at 102.) Plaintiff has never been married and does not have any children. (Id. at 72, 224.) He lives with his older brother, James Coleman, in a trailer inherited from their mother, in a senior trailer park community. (Id. at 273.)

III. MEDICAL EVIDENCE

A. Dr. Joel Juarez Uribe, Sharp Healthcare Chula Vista

Plaintiff was seen at Sharp Healthcare in March and June 2002 for hypertensive cardiovascular disease, high blood pressure, anxiety, hyperlipidemia (elevated level of lipids in blood), and chronic obstructive pulmonary disease. (Id. at 173-76.) A chest CT scan taken in July 2002 was unremarkable. (Id. at 177.)

B. South Bay Guidance Center - Treating Psychiatrist (2003)

Plaintiff was first seen at the South Bay Guidance Center in March 2003 at the referral of his primary care physician. (Id. at 260.) He reported that he started drinking alcohol and using marijuana at the age of 11, used speed at age 14, and sold speed in high school. The peak of his substance abuse was in the mid-1980s. He stated that he had been clean for five years. He complained of anxiety, worry, hopelessness, helplessness, fear of relapsing, depressed mood, and fear of being unable to care for his elderly mother, with whom he then lived. (Id.) His primary care doctor had prescribed Paxil and Diazepan (Valium); he was not satisfied with the Valium and had finished the bottles early. (Id.) Plaintiff was instructed to discontinue the Valium, and was prescribed Buspar (for anxiety) and Klonopin (a benzodiazepine used to produce a calming effect). (Id. at 259.)

C. San Ysidro Health Center - Treating Physician(s) (2004)

Plaintiff was seen at the San Ysidro Health Center during the early part of 2004. (Id. at 321-36.) In February 2004, he admitted that he had been taking more Klonopin than he should but stated that his anxiety had been overwhelming. (Id. at 324.)

His physician agreed to fill the prescription but warned Plaintiff that all further refills had to come from his psychiatrist. (Id.) The following month, Plaintiff complained of pain in both legs and feet. (Id. at 323.) In April 2004, he had an anxiety attack and reported that he had been discharged from treatment at the South Bay Guidance Center. (Id. at 322.) The doctor discovered that Plaintiff had been discharged for misuse of "benzo" (benzodiazepine) and that he exhibited symptoms of benzo withdrawal. (Id.)

D. Alvarado Hospital (December 31, 2004 - January 2, 2005)

Plaintiff was admitted into Alvarado Hospital between December 31, 2004 and January 2, 2005 with complaints of a panic attack and tachycardia (rapid heartbeat). (Id. at 179.) He had been trying to enter a detoxification facility but was shaky and had a fever so was taken to the hospital. (Id. at 183.) Plaintiff was diagnosed with pneumonia. (Id. at 179.) He was also found to have an elevated level of alcohol in his body. (Id. at 179.) He reported that he drank one quart of alcohol daily and that his last drink had been the previous morning. (Id. at 185.) He discharged himself from the hospital without telling any of the medical staff. (Id. at 179.)

E. Scripps Memorial Chula Vista (January 2005)

The day after walking out of Alvarado Hospital, Plaintiff presented to the emergency room at Scripps Memorial Chula Vista with complaints of chest pain, shortness of breath, shakes, and jitters. (Id. at 223.) He explained that he had left Alvarado Hospital against medical advice as he felt he had been receiving poor care there. (Id.) He advised that he had been hospitalized

for alcohol and drug use numerous times in the past, and admitted to drinking one quart of whiskey or other heavy alcohol per day. (Id. at 224.) Plaintiff was treated for his pneumonia and released. (Id. at 229.)

F. San Ysidro Health Center - Treating Physician(s) (2005)

Plaintiff admitted to increased alcohol consumption and requested medication for anxiety during a visit to the San Ysidro Health Center in early 2005. (Id. at 320.) He was given a trial prescription of Zoloft, but elected to take Paxil instead. (Id. at 319-20.) He complained of headaches, as well as joint, muscle, knee and back pain. (Id. at 317-18.) X-rays taken in April 2005 showed mild degenerative changes in both knees and an old compression fracture at L3. (Id. at 212-14, 316.) Plaintiff was referred to physical therapy, which he attended from May to June 2005. (Id. at 206-11, 256-58, 316.) Bilateral knee x-rays taken in June 2005 showed only minimal patella spurring. (Id. at 371.)

Plaintiff continued to be seen during 2005 for chronic low back pain, for which he was prescribed a fentanyl patch and given referrals for pain management, an orthopedic evaluation, and physical therapy. (Id. at 309-11, 313-15.)

G. UCSD Medical Center (2005)

Plaintiff underwent an orthopedic consultation in September 2005 at the UCSD Medical Center in Hillcrest for his low back pain. (Id. at 384-86.) He described his pain as aching and stated that he had injured his back after falling off of a truck in 1995. (Id. at 385.) Although he had previously been able to manage his pain with various medications, including Vicodin and

Fentanyl patches, his pain had gotten progressively worse. (Id.) After Dr. Yo-Po Lee, an orthopedic surgeon, discussed the risks and benefits of surgical intervention, Plaintiff advised that he was not interested in surgery. (Id.) Dr. Lee referred Plaintiff to a pain management physician.

Plaintiff visited the UCSD Pain Clinic the following month and saw Dr. Albert Y. Lung. (Id. at 383-84.) Plaintiff described his back pain level as 8 on a scale of 10, but declined having any radiating pain into his legs. (Id. at 383.) Dr. Lung reviewed Plaintiff's lumbar MRI findings from August 26, 2005 and opined that Plaintiff's low back pain was probably being caused by the L3 compression fracture. (Id. at 383-84, 467-68.) Dr. Lung indicated that there was nothing the Pain Clinic could offer Plaintiff to treat his pain, and recommended that Plaintiff see Interventional Radiology for vertebroplasty, a surgical treatment, for pain relief. (Id. at 384.)

H. South Bay Guidance Center - Treating Psychiatrist (2005)

Plaintiff returned to the South Bay Guidance Center in April 2005 and was seen by Dr. Alexander Papp. (Id. at 255.) He reported that he was feeling "worse again" because his brother had been pressuring him to look for a job. He advised that he had last worked a year previously, and was let go from a box boy job at Vons after a 60 day trial period. (Id.) Plaintiff advised that his brother was supporting him and that this created tension between the two of them. Plaintiff's medications included Trazodone (for insomnia), Klonopin (for agitation), Depakote (for mood swings), and Effexor (for anxiety and agoraphobia). Plaintiff requested that his dosage of Klonopin be

doubled, but Dr. Papp declined to do so due to Plaintiff's prior history of drug abuse. (Id.) Dr. Papp switched Plaintiff to Effexor for his anxiety and agoraphobia as Paxil CR was no longer on the market. (Id.)

Dr. Papp indicated that Plaintiff's diagnoses included depressive disorder in partial remission and polysubstance abuse in remission, and questioned whether Plaintiff had bipolar traits. (Id. at 240.) In later visits in 2005, Dr. Papp noted that Plaintiff was less nervous outside of the home, had occasional tearfulness when he thought about his mother, who had recently passed away, and was having trouble sleeping. (Id. at 244-48.) Plaintiff continued having serious conflicts with his brother and also had a falling out with his AA sponsor. (Id. at 242-45, 357-62.)

I. Dr. Sandra Eriks, Seagate Medical Group - Examining Physician (2005)

Plaintiff underwent an internal medicine evaluation with Dr. Sandra Eriks of Seagate Medical Group on December 19, 2005 at the request of the Department of Social Services. (Id. at 268-71.) Plaintiff reported that he lived with his brother and that they supported themselves on his brother's Social Security Disability. (Id. at 269.) Dr. Eriks observed that Plaintiff was "somewhat somnolent" and "very slowed," which she attributed to the use of high-dose narcotics. (Id. at 271.) She reported that Plaintiff had a long-standing history of low back pain, and opined that Plaintiff had the residual functional capacity ("RFC") to lift and carry 20 pounds occasionally and 10 pounds frequently, stand and/or walk 2 hours out of an 8 hour day, and sit for 2 hours out

of an 8 hour day. (Id.)

J. Dr. Jaga Nath Glassman - Examining Psychiatrist (2005)

Plaintiff received a psychiatric disability evaluation from Dr. Jaga Nath Glassman on December 23, 2005 at the request of the Department of Social Services. (Id. at 273-77.) Plaintiff explained that he had last worked in 2001 at Vons, and that he was let go after two months because he "didn't fit in" in terms of "the mental aspects." (Id. at 273.) Plaintiff stated that he felt incapable of working because he did not get along with people and because of his depression, anxiety, and anger issues. (Id. at 274.)

Dr. Glassman concluded:

> This 49-year-old single Caucasian male describes longstanding problems of not fitting i[n], identity confusion, feeling "lonely," low self-esteem, labile affect states, and intermittent depression and anxiety. He also apparently has an extensive history of polysubstance abuse, that he denied to me during the interview. [¶] In formal diagnostic terms, one might consider the following:
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> Axis I - Dysthymic Disorder; Apparent Polysubstance Abuse - In Remission - Including Alcohol and Possibly Methamphetamine; Ongoing Benzodiazepine Dependence (6 mg of clonazepam a day).
>
> Axis II - Borderline Personality Features; Possible Borderline Intellectual Functioning.
>
> Axis III - Obesity, hypertension.

(Id. at 276-77.)

K. Various Hospitals (2006)

Plaintiff was seen at the emergency room at Scripps Mercy Hospital on January 22, 2006. (Id. at 396-97.) The doctor was initially unable to ascertain Plaintiff's problems, but was eventually able to do so upon the arrival of Plaintiff's brother.

(Id. at 396.) It came out that Plaintiff had stolen some of his brother's medications, used them to buy alcohol, and had been drinking heavily for the past few days. (Id.) The emergency room physician advised Plaintiff to return to his treating doctors at the San Ysidro Health Center and to restart his Vicodin and Fentanyl patches, which Plaintiff had been without for 5-10 days. (Id. at 397.)

On February 5, 2006, Plaintiff's sponsor took Plaintiff to the emergency room at Sharp Memorial Hospital after he overdosed on Klonopin. (Id. at 409.) He had taken a total of 90 Klonopin tablets because he "wanted to die." (Id.) He stated that he was experiencing feelings of worthlessness, hopelessness, and guilt after stealing from his brother. (Id.) Plaintiff reported that he was a binge drinker, and the doctor noted that Plaintiff had been dependent upon opiates and benzodiazepines. (Id.) Plaintiff's diagnoses included psychiatric decompensation, obesity, chronic back pain, history of lumbar compression fracture, alcoholism, hypertension, and hyperlipidemia. (Id. at 410.) Plaintiff stayed at the hospital until February 13, 2006, when he was discharged to the Jary Barreto Crisis Center. (Id. at 411, 445-56.) He stayed there until February 28, 2006, at which time he was discharged to his brother's house following an agreement between Plaintiff, his brother, and Dr. Jennifer Poast of San Ysidro Health Center regarding the administering of Plaintiff's medications. (Id. at 304, 445.)

Following his stay at the crisis center, Plaintiff appeared to be doing better as Seroquel, an antipsychotic mediation, had been added to his medication regimen. (Id. at 346-53.) It was

noted, however, that Plaintiff appeared to be either drinking too much or taking too much of his medications. (Id. at 341.)

Plaintiff was admitted into Scripps Mercy Hospital between July 7 and 11, 2006 following another suicide attempt. (Id. at 398-407.) Plaintiff reported that he and his brother had had an argument, and that he had relapsed to whiskey after being sober for six months. (Id. at 400.) Plaintiff had also stopped taking his medications. (Id. at 401.) Plaintiff was diagnosed with severe depression, and was discharged once he had stabilized. (Id. at 398, 401-02.)

L. South Bay Guidance Center - Treating Psychiatrist (2006)

As of July 25, 2006, Plaintiff was taking Trazodone, Klonopin, Seroquel, and Cymbalta for his psychiatric issues. (Id. at 460.) Dr. Papp noted that Depakote and Effexor had been discontinued, and prescribed Cymbalta for use as an antidepressant. (Id. at 459.) Plaintiff appeared to have good results with Cymbalta. (Id. at 462, 464, 486.)

On October 24, 2006, Dr. Papp completed a Psychiatric Review Form on behalf of Plaintiff. (Id. at 378-81.) He noted that Plaintiff's diagnosis was Depressive Disorder, and that his current Global Assessment of Functioning ("GAF") score was 39.[1] (Id. at 378.) He opined that Plaintiff's symptoms adversely

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[1]The Global Assessment of Functioning scale, or GAF scale, is a numeric scale (0 through 100) used by mental health practitioners to rate social, occupational, and psychological functioning, with lower numbers representing more severe symptoms, difficulties, or impairments. The scale is presented in the Diagnostic and Statistical Manual of Mental Disorders. A GAF score between 31 and 40 suggests "Some impairment in reality testing or communication OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood." American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision (2000).

affected his functioning such that he would be absent from a job more than three times per month, that Plaintiff had "marked" limitations in three areas of functioning, and that Plaintiff would experience one or two repeated episodes of decompensation. (Id. at 380-81.) In a letter to Plaintiff's counsel dated November 7, 2006, Dr. Papp wrote that Plaintiff had stopped using stimulants four years before and alcohol two years before, and that "[h]is mood swings, depression, [and] anxiety, have all continued to remain [the] focus of attention after he had attained full sobriety." (Id. at 465.)

IV. THE ADMINISTRATIVE HEARING

The ALJ conducted administrative hearings on November 20, 2006 and January 18, 2007. (Id. at 499, 525.)

A. First Administrative Hearing

1. Plaintiff's Testimony

Plaintiff testified that he lives with his brother and that his brother supports him. (Id. at 502-03.) He denied abusing benzodiazepine. (Id. at 503.) He stated that he was unable to work because of his back impairment. (Id. at 505.) He testified that he feels depressed off and on every day, has problems communicating with others, doesn't "fit in," and has short term memory problems, low concentration, and a low comprehension level. (Id. at 505-08.) He also stated that he does not finish things he starts, and feels nervous and anxious around people. (Id. at 508-09.) He testified that he last drank alcohol a year before. (Id. at 510.) He stated that he can walk only a block before feeling back pain, has pain after standing for 30 minutes, and has to adjust every 20-30 minutes when sitting. (Id. at

511.)

2. Medical Expert Testimony

Walter Doren, M.D., an orthopedist, testified as a medical expert ("ME") at the first administrative hearing. Dr. Doren testified that Plaintiff had an old compression fracture at L3, but the quantification of the degree was not expressed in the x-rays that were presented. (Id. at 515.) He stated that Plaintiff did not meet or equal any of the listings in the Listing of Impairments in relation to his spinal cord because there was no description of any substantial deformation concerning Plaintiff's L3 vertebral fracture and because the records indicated that Plaintiff did not have any neurological deficits. (Id. at 515-17.) Though he stated that he agreed with Dr. Eriks' opinion regarding Plaintiff's RFC, Dr. Doren testified that Plaintiff was capable of standing or walking for 6 hours and sitting for 6 hours out of an 8 hour day. (Id. at 517; contra id. at 271 [setting forth Dr. Eriks' opinion that Plaintiff could stand or walk for *2* hours and could sit for *2* hours out of an 8 hour day].) Dr. Doren also testified that Plaintiff would require a sit/stand option. (Id. at 517.) In response to questioning by Plaintiff's counsel, Dr. Doren testified that he could not comment on Plaintiff's lumbar MRI findings as he had not seen the MRI report. (Id. at 518.)

3. Vocational Expert Testimony

Vocational expert ("VE") witness Mary Jesko testified at the first administrative hearing. In response to a hypothetical question posed by the ALJ, the VE testified that a person with a sit/stand option, limited to occasional bending and crawling,

limited to simple, repetitive tasks, with no public contact and minimal interaction with coworkers and supervisors, could not perform Plaintiff's prior work. (Id. at 520-21.) However, such a person could perform work as a small parts assembler, textile filler, and gluer. (Id. at 521-22.) Upon questioning by Plaintiff's counsel, the VE stated that a person limited to the RFC put forth by Dr. Eriks (see id. at 271) could not perform these jobs on a full-time, 40 hour per week basis because of the two hour limitations upon standing or walking and sitting. (Id. at 523.)

B. Second Administrative Hearing

Sidney Bolter, M.D., a Board-certified psychiatrist, testified as a ME at the second administrative hearing. (Id. at 527.) Dr. Bolter testified that Plaintiff did not meet or equal any of the psychiatric or psychological listings. (Id. at 529-30.) He further opined:

> My diagnosis here, when you put it all together, is depression NOS [not otherwise specified] with the -- the actual decompensations which he was in the hospital were related to substances. His depression, nevertheless, without substances is moderate, moderate for activities, moderate for social functioning, mild but I would restrict him to simple, repetitive tasks, non-public. He should be okay with supervisors and coworkers. And decompensation with the substances, according to the record, would be about three; and without would just be one to two, being that he's in treatment.

(Id. at 531.)

V. THE ALJ DECISION

After considering the record, ALJ Carletti made the following findings:

. . . .

> 2. The claimant has not engaged in substantial gainful activity at any time relevant to this decision [citations omitted].
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> 3. The claimant has the following severe impairments: degenerative disc disease, degenerative joint disease, depressive disorder, anxiety disorder, and polysubstance dependence [citations omitted].[2]
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> . . . .
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> 4. Without polysubstance dependence, the claimant does not have an impairment or combination of impairments that meets or medically equals one of the listed impairments in [the Social Security Regulations]. With polysubstance dependence, the claimant's impairments meet the criteria of medical listings 12.04, 12.06, and 12.09 [citations omitted].
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> 5. After careful consideration of the entire record, the undersigned finds that the claimant has the residual functional capacity, without polysubstance dependence, to perform light work, with a sit/stand option, and occasional bending or crawling, involving simple repetitive tasks in nonpublic settings.
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> . . . .
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> 6. The claimant is unable to perform any of his past relevant work as a bagger, molder, or stocker. So opined the vocational expert, and I concur and so find [citation omitted].
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> . . . .
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> 10. Considering the claimant's age, education, work experience, and residual functional capacity without polysubstance dependence, there are jobs that exist in significant numbers in the national economy that the claimant can perform [citations omitted].
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> . . . .

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[2]"An 'individual shall not be considered to be disabled for purposes of [benefits under Title II or XVI of the Act] if alcoholism or drug addiction would . . . be a contributing factor material to the Commissioner's determination that the individual is disabled.'" Bustamonte v. Massanari, 262 F.3d 949, 954 (9th Cir. 2001) (citing 42 U.S.C. §§ 423(d)(2)(C), 1382c(a)(3)(J)). According to the SSA's implementing regulations, "If we find that you are disabled and have medical evidence of your drug addiction or alcoholism, we must determine whether your drug addiction or alcoholism is a contributing factor material to the determination of disability." 20 C.F.R. §§ 404.1535(a), 416.935(a).

> 11. The claimant's polysubstance dependence is a contributing factor material to the determination of disability, and the claimant has not been entitled to or eligible for Social Security benefits pursuant to Titles II or XVI of the Social Security Act, from January 1, 2002, through the date of this decision [citations omitted].

(Id. at 17-22.)

VI. STANDARD OF REVIEW

To qualify for disability benefits under the Social Security Act, an applicant must show that: (1) He or she suffers from a medically determinable impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of twelve months or more, and (2) the impairment renders the applicant incapable of performing the work that he or she previously performed or any other substantially gainful employment that exists in the national economy. See 42 U.S.C. § 423(d)(1)(A), (2)(A). An applicant must meet both requirements to be "disabled." Id. Further, the applicant bears the burden of proving that he or she was either permanently disabled or subject to a condition which became so severe as to disable the applicant prior to the date upon which his or her disability insured status expired. Johnson v. Shalala, 60 F.3d 1428, 1432 (9th Cir. 1995).

A. Sequential Evaluation of Impairments

The Social Security Regulations outline a five-step process to determine whether an applicant is "disabled." The five steps are as follows: (1) Whether the claimant is presently working in any substantial gainful activity. If so, the claimant is not disabled. If not, the evaluation proceeds to step two. (2) Whether the claimant's impairment is severe. If not, the

claimant is not disabled. If so, the evaluation proceeds to step three. (3) Whether the impairment meets or equals a specific impairment listed in the Listing of Impairments. If so, the claimant is disabled. If not, the evaluation proceeds to step four. (4) Whether the claimant is able to do any work he has done in the past. If so, the claimant is not disabled. If not, the evaluation continues to step five. (5) Whether the claimant is able to do any other work. If not, the claimant is disabled. Conversely, if the Commissioner can establish there are a significant number of jobs in the national economy that the claimant can do, the claimant is not disabled. 20 C.F.R. § 404.1520; see also Tackett v. Apfel, 180 F.3d 1094, 1098-99 (9th Cir. 1999).

B. Judicial Review

Sections 205(g) and 1631(c)(3) of the Social Security Act allow unsuccessful applicants to seek judicial review of the Commissioner's final agency decision. 42 U.S.C.A. §§ 405(g), 1383(c)(3). The scope of judicial review is limited. The Commissioner's final decision should not be disturbed unless: (1) The ALJ's findings are based on legal error or (2) are not supported by substantial evidence in the record as a whole. Schneider v. Comm'r of Soc. Sec. Admin., 223 F.3d 968, 973 (9th Cir. 2000). Substantial evidence means "more than a mere scintilla but less than a preponderance; it is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Andrews v. Shalala, 53 F.3d 1035, 1039 (9th Cir. 1995). The Court must consider the record as a whole, weighing both the evidence that supports and detracts from the ALJ's

conclusion. See Mayes v. Massanari, 276 F.3d 453, 459 (9th Cir. 2001); Desrosiers v. Sec'y of Health & Human Servs., 846 F.2d 573, 576 (9th Cir. 1988). "The ALJ is responsible for determining credibility, resolving conflicts in medical testimony, and for resolving ambiguities." Vasquez v. Astrue, 547 F.3d 1101, 1104 (9th Cir. 2008) (citing Andrews, 53 F.3d at 1039). Where the evidence is susceptible to more than one rational interpretation, the ALJ's decision must be affirmed. Vasquez, 547 F.3d at 1104 (citation and quotations omitted).

Section 405(g) permits this Court to enter a judgment affirming, modifying, or reversing the Commissioner's decision. 42 U.S.C.A. § 405(g). The matter may also be remanded to the SSA for further proceedings. Id.

VII. DISCUSSION

A. The ALJ Erred by Failing to Consider James Coleman's Lay Witness Testimony

Plaintiff first argues that the ALJ erred by failing to address the third party statements of Plaintiff's brother, James Coleman ("James"), in his decision. (Pl.'s Mem. at 20-22.) Defendant argues in response that the ALJ's failure to discuss James' statements was harmless as the statements were not probative and would not have significantly impacted the ALJ's decision. (Def.'s Opp'n at 4-6.)

In the Ninth Circuit, "the ALJ is required to account for all lay witness testimony in the discussion of his or her findings." Robbins v. Soc. Sec. Admin., 466 F.3d 880, 885 (9th Cir. 2006) (citing Lewis v. Apfel, 236 F.3d 503, 511 (9th Cir. 2001) ("Lay testimony as to a claimant's symptoms is competent

evidence that an ALJ must take into account, unless he or she expressly determines to disregard such testimony and gives reasons germane to each witness for doing so.")). "[L]ay witness testimony as to a claimant's symptoms or how an impairment affects ability to work *is* competent evidence . . . and therefore *cannot* be disregarded without comment." Nguyen v. Chater, 100 F.3d 1462, 1467 (9th Cir. 1996) (emphasis in original). "[W]here the ALJ's error lies in a failure to properly discuss competent lay testimony favorable to the claimant, a reviewing court cannot consider the error harmless unless it can confidently conclude that no reasonable ALJ, when fully crediting the testimony, could have reached a different disability determination." Stout v. Comm'r, 454 F.3d 1050, 1056 (9th Cir. 2006).

Here, James Coleman completed four "Function Report Adult - Third Party" forms, presumably at the behest of the SSA, between May and October 2005. See Admin. R. at 80-88, 110-18, 127-34 and 151-58. James reported, *inter alia*, that he needed to explain things more than once to Plaintiff, and that Plaintiff complained that it hurt to do things, did not sleep regularly, could only watch television, had stopped all activities because his back condition was getting worse, could stand for only 10-15 minutes, forgot a lot, stopped jobs in the middle of doing them, could not understand simple things, and could pay attention for only 10-20 minutes. (Id. at 115, 152, 155, 156.) Such testimony, if fully credited, supports a conclusion that Plaintiff is unable to work. "[F]riends and family members in a position to observe a claimant's symptoms and daily activities are competent to testify as to [his] condition." Dodrill v. Shalala, 12 F.3d 915, 918-99

(9th Cir. 1993). The ALJ, who wholly failed to mention James' reports about Plaintiff's impairments in his decision, thus erred. See, e.g., Stout, 454 F.3d at 1054; see also Bruce v. Astrue, --- F.3d ----, 2009 WL 539945 (9th Cir. Mar. 5, 2009) (finding that the ALJ failed to adequately address competent lay witness testimony provided by the claimant's wife).

Defendant argues that the ALJ's failure was harmless as the reports submitted by James were not probative. The Court disagrees. Numerous regulations direct the ALJ to consider, throughout the sequential process, lay testimony and/or evidence by non-medical sources concerning the severity of a claimant's impairment and the claimant's ability to work. See, e.g., 20 C.F.R. §§ 404.1513(d)(4), 404.1529(c)(3), 404.1545(a)(3), 416.913(d)(4), 416.929(c)(3), 416.945(a)(3). Furthermore, the Ninth Circuit specifically noted in Stout that no legal authorities have concluded that an ALJ's silent disregard of lay testimony was harmless. See Stout, 454 F.3d at 1055-56. Defendant has provided no authority to the contrary.

In sum, the Court cannot conclude that if James' testimony were fully credited, no reasonable ALJ could find Plaintiff fully disabled and unable to work. Accordingly, the Court cannot conclude that the ALJ's error in failing to consider James' competent lay testimony was harmless. See id. at 1056. The Court therefore remands this matter for further proceedings regarding James Coleman's lay testimony concerning Plaintiff's symptoms and ability to work.

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B. Remand is Required to Ascertain the Effect of Plaintiff's MRI Findings Upon Dr. Doren's Opinions

Plaintiff next argues that the RFC assigned to Plaintiff by the ALJ is not supported by substantial evidence as it is based upon the conclusions of Dr. Doren, one of the MEs, whose opinion did not incorporate all of Plaintiff's objective medical evidence. (Pl.'s Mem. at 22-25.) Specifically, Plaintiff contends that Dr. Doren's opinion did not take Plaintiff's lumbar MRI findings into consideration. (Id. at 23-25.)[3] Defendant argues in response that Plaintiff's MRI findings were not as important as evidence regarding his actual functioning, that Plaintiff did not submit the MRI report to the ALJ in a timely manner, and that the ALJ was under no obligation to provide the MRI findings to Dr. Doren for comment after the November 20, 2006 hearing. (Def.'s Opp'n at 6-9.)

Plaintiff's lumbar MRI dated August 26, 2005 demonstrated that Plaintiff had "Severe L2-3, moderate L3-4, and mild L4-5 multi-level acquired lumbar central canal stenosis[,] . . . Moderately severe bilateral L3 and moderate bilateral L4 lateral recess stenosis[, and] Moderate bilateral L2-3 and mild bilateral L3-4 foraminal stenosis." (Admin. R. at 468.) It also showed an "Old moderately severe anterior wedge shape superior L3 vertebral body compression fracture with 5 mm posterior-superior

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[3]Plaintiff actually argues that Dr. Doren did not take Plaintiff's lumbar *and* cervical MRI results into consideration, and refers to the report located on page 469 of the administrative record as a report of a cervical MRI. That report, however, is a report of cervical *x-rays* ordered by Dr. Donald Vance during Plaintiff's emergency room visit on September 12, 2005. (See Admin. R. at 203-05, 469.) There does not appear to be a report of a cervical MRI in the record.

retropulsed component." (Id.) Lumbar spinal stenosis is a condition in which either the spinal canal (central stenosis) or vertebral foramen (foraminal stenosis) becomes narrowed. See http://www.medicinenet.com/lumbar_stenosis/article.htm (as visited Mar. 6, 2009). If the narrowing is substantial, it can cause nerve compression, which results in back pain. Id.

In his testimony at the first administrative hearing, Dr. Doren, who had reviewed the brief summary of the MRI contained in the report of Dr. Wong of the UCSD Pain Clinic (see Admin. R. at 389), but had not reviewed the MRI report itself, commented, "[U]nfortunately, there was not any record of the MRI in the exhibits that were provided for me." (Id. at 515-16.) Dr. Doren also stated that the "quantification of the degree" of Plaintiff's L3 compression fracture was not contained in Plaintiff's lumbar x-ray report, which he had reviewed (see id. at 212, 514-55), and that he could not assess Plaintiff's central canal stenosis because he did not have the MRI report (see id. at 518). Therefore, although Dr. Doren found that Plaintiff did not exhibit any neurological deficits (see id. at 517), as Dr. Doren's own testimony clearly shows, the lumbar MRI report would have permitted his opinions to be more accurate and complete. Dr. Doren would have been able to properly evaluate the extent and severity of Plaintiff's L3 compression fracture and spinal stenosis, and the impact of those findings on Plaintiff's RFC.

Defendant asserts that Plaintiff did not submit the MRI report in a timely manner and that the ALJ was under no obligation to provide the MRI findings to Dr. Doren for comment after the November 20, 2006 hearing. According to the record,

Plaintiff's counsel submitted the MRI report, along with other records, *one day* after the first administrative hearing, apparently after realizing that the record did not contain those reports. (See id. at 466-68.)

The ALJ in a social security case has a "special duty to fully and fairly develop the record and to assure that the claimant's interests are considered." Smolen v. Chater, 80 F.3d 1273, 1288 (9th Cir. 1996) (citation omitted). This duty exists even when the claimant is represented by counsel. Brown v. Heckler, 713 F.2d 441, 443 (9th Cir. 1983). The ALJ's duty to develop the record is triggered when there is ambiguous evidence or when the record is inadequate to allow for the proper evaluation of the evidence. Mayes, 276 F.3d at 459-60. The ALJ may discharge this duty in several ways, including by subpoenaing the claimant's physicians, submitting questions to the claimant's physicians, continuing the hearing, or keeping the record open after the hearing to allow supplementation of the record. Tonapetyan v. Halter, 242 F.3d 1144, 1150 (9th Cir. 2001).

Given the ALJ's duty to fully develop the record, as well as his reliance on Dr. Doren's opinions, it would have been prudent for the ALJ to provide the MRI report to Dr. Doren for evaluation and comment, even after the first administrative hearing had taken place. This is especially true considering that the subject record was provided immediately after the hearing and well in advance of both the ALJ's decision, which was issued on February 9, 2007, as well as the second administrative hearing, which took place on January 18, 2007. The ALJ easily could have provided the MRI report to Dr. Doren and requested that Dr. Doren

provide supplemental testimony at the second hearing. In failing to do so, he failed to fulfill his duty to fully develop the record, and thus erred.

The Court directs that upon remand, the ALJ shall conduct further proceedings in order to obtain an opinion from Dr. Doren or other ME which takes all of the pertinent medical evidence into account, including Plaintiff's 2005 lumbar MRI findings.

C. The ALJ Did Not Err by Not Incorporating "One or Two Episodes of Decompensation" Into Plaintiff's RFC

Plaintiff argues that the ALJ erred in formulating Plaintiff's RFC by not properly accounting for significant work absences caused by episodes of decompensation. (Pl.'s Mem. at 25-26.) Plaintiff observes that although the ALJ stated that Plaintiff would have "one or two episodes of decompensation" without polysubstance dependence (see Admin. R. at 18), the ALJ did not include this finding in his assessment of Plaintiff's RFC. Defendant argues in response that the ALJ did not find that Plaintiff had a RFC that included extended periods of decompensation, and that Plaintiff has erroneously conflated "preliminary evidentiary findings" with the ALJ's ultimate RFC determination. (Def.'s Opp'n at 9-12.)

Plaintiff's arguments rest on two erroneous assumptions. First, "episodes of decompensation" are defined as "exacerbations or temporary increases in symptoms or signs accompanied by a loss of adaptive functioning." 20 C.F.R. pt. 404, subpt. P, app. 1, § 12.00C(4). Each such episode does *not*, as Plaintiff contends, necessarily last for at least two weeks. See Pl.'s Mem. at 26. Rather, it is episodes of *extended* duration that are defined as

lasting for at least two weeks. See 20 C.F.R. pt. 404, subpt. P, app. 1, § 12.00C(4). The language of Listing 12.00 makes it clear that it is possible for episodes of decompensation to be of a shorter duration than two weeks. See id. Therefore, Plaintiff's assumption that the one or two episodes of decompensation described by Dr. Bolter and the ALJ would result in Plaintiff missing two two-week periods of work each year is erroneous.

Second, Defendant is correct that the ALJ's finding, based upon Dr. Bolter's testimony, that Plaintiff would have one or two periods of decompensation related not to the RFC determination at steps four and five of the sequential evaluation process, but rather to the determination at step two whether Plaintiff's mental impairments were severe (as well as to the step three analysis). The psychiatric review technique described in 20 C.F.R. §§ 404.1520a and 416.920a requires the ALJ to assess a claimant's limitations and restrictions from a mental impairment in categories identified as the "paragraph B" and "paragraph C" criteria of the adult mental disorders listings. SSR 96-8P, 1996 WL 374184, at *4; 20 C.F.R. §§ 404.1520a, 416.920a. "Episodes of decompensation" are one of the four components of the paragraph B criteria. 20 C.F.R. pt. 404, subpt. P, app. 1, § 12.00C. SSR 96-8P expressly provides, "The adjudicator must remember that the limitations identified in the 'paragraph B' and 'paragraph C' criteria *are not an RFC assessment* but are used to rate the severity of mental impairment(s) at steps 2 and 3 of the sequential evaluation process." SSR 96-8P, 1996 WL 374184, at *4 (emphasis added). "RFC is a multidimensional description of the

work-related abilities you retain in spite of your medical impairments. An assessment of your RFC complements the functional evaluation necessary for paragraphs B and C of the listings by requiring consideration of an expanded list of work-related capacities that may be affected by mental disorders when your impairment(s) is severe but neither meets nor is equivalent in severity to a listed mental disorder." 20 C.F.R. pt. 404, subpt. P, app. 1, § 12.00A. Thus, the determination of a claimant's RFC is distinct from the examination of the degree of functional limitation that takes place when assessing whether a claimant's impairment is "severe" at step two or whether it meets a listing at step three. See, e.g., Langford v. Astrue, 2008 WL 2073951, at *3 (E.D. Cal. 2008) (finding that the ALJ was under no obligation to incorporate the findings from the psychiatric review technique in his ultimate assessment of plaintiff's RFC at steps four and five); see also Lopez v. Astrue, 2008 WL 3539623, at *7 (N.D. Cal. 2008) (finding the same).

The Court concludes that the ALJ did not commit error by not including the "one or two episodes of decompensation" in his determination of Plaintiff's RFC.

D. Remand is Appropriate

The ALJ erred by failing to consider the lay witness testimony of Plaintiff's brother, James Coleman, and by failing to ascertain the effects of Plaintiff's lumbar MRI findings upon the opinion of Dr. Doren. Remand is warranted when additional administrative proceedings can remedy defects in the original decision. Lewin v. Schweiker, 654 F.2d 631, 635 (9th Cir. 1981). Accordingly, remand is the proper remedy in this case.

VIII. CONCLUSION

Based on the foregoing, Plaintiff's Motion for Summary Judgment is **GRANTED** and Defendant's Cross-Motion for Summary Judgment is **DENIED**. Pursuant to Section 405(g) of Title 42, this case should be remanded to the Social Security Administration for further administrative proceedings consistent with the discussion above.

IT IS SO ORDERED.

DATED: March 26, 2009

Hon. Jeffrey T. Miller
United States District Judge